

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08184

8213

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Pennsylvania b. COUNTY Pittsburgh			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. LENGTH OF STAY IN 1b 11yrs. 5mo. 30days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 97 Steuben Street			
3. NAME OF DECEASED (Type or print) First JAMES Middle W. Last BANNON				4. DATE OF DEATH Month August Day 8 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-9-1887	
9. AGE (In years lost birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John Bannon				14. MOTHER'S MAIDEN NAME Mary Tracey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> WW I				16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary arteriosclerosis, severe DUE TO (b) Myocardial fibrosis DUE TO (c) Infarcts of the lungs, bilateral, multiple							INTERVAL BETWEEN ONSET AND DEATH unknown unknown 10-15 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, generalized, severe (unknown)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 VA				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from February 9, 1945, to August 8, 1956, and that death occurred at 9:35 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. Oppler				M.D. V.A. Hospital, Perry Point, Md. DATE SIGNED 8-10-56			
PHYSICIAN'S NAME (Type) W. OPPLER				Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 8-10-56		22c. NAME OF CEMETERY OR CREMATORY Unknown		22d. LOCATION (City, town, or county) (State) Pittsburgh, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS Navre de Grace, Md.		24a. REC'D BY REGISTRAR DATE 8-18-56	
						24b. REGISTRAR'S SIGNATURE Irene E. Dougherty	

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MEDICAL CERTIFICATION

RECEIVED

8214

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Elkton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R. D. #4, Elkton, Maryland		d. STREET ADDRESS B. D. #4, Elkton, Md.	
3. NAME OF DECEASED (Type or print) First Middle Last Lissie Oaks Barnett		4. DATE OF DEATH Month Day Year August 4, 19 56	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 22, 1888
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Clement Oaks		14. MOTHER'S MAIDEN NAME Sarah Hughes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 242125141	
17. INFORMANT Mr. Paul Barnett, RD #4, Elkton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral vascular accident 331X DUE TO (b) Essential hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			INTERVAL BETWEEN ONSET AND DEATH 7 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 28, 19 56, to Aug. 4, 19 56, that I last saw the deceased alive on July 28, 19 56, and that death occurred at 4:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Kenneth W. Eskew, M.D.		ADDRESS (Street, city or town, state) Brookside, Newark, Del.	
PHYSICIAN'S NAME (Type) Kenneth W. Eskew		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-7-56	22c. NAME OF CEMETERY OR CREMATORY Faggs Manor Cemetery	22d. LOCATION (City, town, or county) (State) Russellville, Penna.
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Pippin		24a. REC'D BY REGISTRAR DATE 8/6/56	24b. REGISTRAR'S SIGNATURE FR Frazer

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08186

8215

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R. D., North East		c. LENGTH OF STAY IN 1b 1 day	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Elkton R. D. 3		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Graybeal Nursing Home	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROSE Middle P. Last BIRD		4. DATE OF DEATH Month August Day 28 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 11, 1882
9. AGE (In years lost birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Albert Phillips		14. MOTHER'S MAIDEN NAME Mary Margaret Poteet	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. William H. Ross, R.D.3 Elkton		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Myocarditis (c) Hypertension 3 yrs. 3 yrs.		INTERVAL BETWEEN ONSET AND DEATH 1 wk.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 27, 1956, to Aug 28, 1956, that I last saw the deceased alive on Aug 27, 1956, and that death occurred at 3:45 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED J. H. HICKS - Elkton Md. JACOB J. GREENWALD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 1, 1956	
22c. NAME OF CEMETERY OR CREMATORY Cherry Hill Meth. Cem.		22d. LOCATION (City, town, or county) (State) Cecil County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks Ralph E. Hicks, Bow & Stockton Sts.		24a. REC'D BY REGISTRAR Aug 31, 56 24b. REGISTRAR'S SIGNATURE L. M. W. H. W. H. W.	

RECEIVED

8216

CERTIFICATE OF DEATH

Reg. Dist. No.

96

1. PLACE OF DEATH o. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u>		c. LENGTH OF STAY IN 1b <u>8 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>200 W. Main St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lewellah</u> First <u>Susan</u> Middle <u>Brenneman</u> Last				4. DATE OF DEATH <u>Aug.</u> Month <u>15</u> Day <u>1956</u> Year			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 27, 1906</u>	9. AGE (In years last birthday) <u>89</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u>15</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Crossroads, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel Kessey</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Meades</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>William Young, Port Deposit Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction - Port Deposit Md.</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Intestinal obstruction -</u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u> <u>4 mos.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Serious</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>52</u> , to <u>8-15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8-15</u> , 19 <u>56</u> , and that death occurred at <u>7:20 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G.H. Richards</u>		M.D. <u>B. H. Hos. T. Md.</u>		ADDRESS (Street, city or town, state)		DATE SIGNED <u>8-15-56</u>	
PHYSICIAN'S NAME (Type) <u>G.H. Richards, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 18, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wintertown Evangelical</u>		22d. LOCATION (City, town, or county) (State) <u>Wintertown Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. D. Burdette</u> ADDRESS <u>Red Lion Pa.</u>				24a. REC'D BY REGISTRAR <u>8-15-56</u>		24b. REGISTRAR'S SIGNATURE <u>Inene E. Langherty</u>	
<u>Lee A. Patterson 4 Son, Pottsville, Md.</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.

RECEIVED
AUG 17 1956
BUREAU V. B.

Item 4 FilmG202 9-6-56 et

8217
8217
CERTIFICATE OF DEATH

Reg. Dist. No. 90

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Cecil		MARYLAND		STATE Md.		COUNTY Cecil	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Chesapeake City		LENGTH OF STAY (in this place) 2 weeks		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN ELKTON			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Morgan Nursing Home				STREET ADDRESS (If rural give location) RD #2			
3. NAME OF DECEASED (Type or Print) Elizabeth Knight Bryant				4. DATE OF DEATH (Month) (Day) (Year) Aug. 7, 1956			
5. SEX F	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Divorced	8. DATE OF BIRTH Jan. 4, 1875	9. AGE last birthday 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housekeeping		11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Bryant				14. MOTHER'S MAIDEN NAME Knight			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Charles H. Bryant, ELKTON, RD #2			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
443X IMMEDIATE CAUSE (A) CEREBRAL HEMORRHAGE						INTERVAL BETWEEN ONSET AND DEATH 48 hours	
ANTECEDENT CAUSE(S) DUE TO (B) Hypertensive C.V. Disease						3 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION NONE		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Aug 15, 1956, to Aug 29, 1956, that I last saw the deceased alive on Aug 28, 1956, and that death occurred at 6:40 A.M. from the causes and on the date stated above.							
SIGNATURE Henry J. Davis M.D.				ADDRESS (Street, city, town, state) Chesapeake City, Md. DATE SIGNED 8/29/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF		NAME OF CEMETERY OR CREMATORY Woodlawn		LOCATION (City, town, or county) Baltimore Md.	
24. REC'D BY REGISTRAR AUG 31 1956		REGISTRAR'S SIGNATURE Mrs. Ralph H. Rees		25. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Vickner & Sons - Balt-Md.		ADDRESS	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8218

CERTIFICATE OF DEATH

Reg. Dist. No.

08189
96

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA COUNTY 47	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 1354 S. Carolina Avenue, S.E.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LEE Middle CAMPBELL Last CAMPBELL		4. DATE OF DEATH Month August Day 26 Year 19 56	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 15, 1899
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Automobile	
11. BIRTHPLACE (State or foreign country) Brandy, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM CAMPBELL		14. MOTHER'S MAIDEN NAME LUCINDA KEITH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Hospital Records, VAH., Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Meningitis, acute 025X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchopneumonia DUE TO Chronic Brain Syndrome associated with Central nervous system syphilis. (Meningoencephalitic) (c) nervous system syphilis. (Meningoencephalitic)		INTERVAL BETWEEN ONSET AND DEATH Unknown Aprox. 4 days Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. 1. Month 19 Day 19 Year 56 p. m. VA		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 9, 1938 , to August 26, 1956 , and that death occurred at 12:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VA HOSPITAL, Perry Point, Md. DATE SIGNED 8-26-56			
ACTUAL SIGNATURE J. C. Grasberger M.D.			
PHYSICIAN'S NAME (Type) J. C. GRASBERGER, M.D., Acting Director, Professional Services,			
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 8-26-56	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Ft. Myer, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE HOTTMAN FUNERAL HOME,		24a. REC'D BY REGISTRAR DATE 8-26-56	
ADDRESS 611 "K" Street, N.W., Washington, D.C.		24b. REGISTRAR'S SIGNATURE Irvin E. Dougherty	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08190

CERTIFICATE OF DEATH

Reg. Dist. No. 96

8219

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PERRY POINT		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX, BALTIMORE	
c. LENGTH OF STAY IN 1b 29yrs 9mos 28days		d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital	
d. STREET ADDRESS 301 East Montrose Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDWARD Middle N. Last CZARNECKY		4. DATE OF DEATH Month August Day 3 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 20, 1897
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) 5/3/22 to 5/14/23	
17. INFORMANT Hospital Records, VAH., Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, lower lobes, 491X DUE TO unresolved Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis of coronary artery DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 to 5 days Unk.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis general, moderate.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 6th , 19 26 , to August 3 , 19 56 , that I saw the deceased alive on 5:20 P.M. , and that death occurred at 5:20 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Joseph Gruberger M.D. VA Hospital, Perry Point, Maryland PHYSICIAN'S NAME (Type) JOSEPH GRASBERGER, Actg. Dir. Prof. Services, VA Hospital, Perry Point, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 8-4-56	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) Essex Maryland
23. FUNERAL DIRECTOR'S SIGNATURE JOHN G. CONNELLY FUNERAL HOMES, Essex 21, Md.		24a. REC'D BY REGISTRAR DATE 8-4-56	24b. REGISTRAR'S SIGNATURE Inez E. Dougherty

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]		4. DATE OF BIRTH [REDACTED]	
5. PLACE OF BIRTH [REDACTED]		6. OCCUPATION [REDACTED]		7. MARITAL STATUS [REDACTED]		8. COLOR [REDACTED]	
9. CAUSE OF DEATH [REDACTED]		10. MANNER OF DEATH [REDACTED]		11. PLACE OF DEATH [REDACTED]		12. TIME OF DEATH [REDACTED]	
13. SIGNATURE OF PHYSICIAN [REDACTED]		14. SIGNATURE OF CORONER [REDACTED]		15. SIGNATURE OF DECEASED [REDACTED]		16. SIGNATURE OF WITNESS [REDACTED]	
17. SIGNATURE OF DECEASED [REDACTED]		18. SIGNATURE OF WITNESS [REDACTED]		19. SIGNATURE OF DECEASED [REDACTED]		20. SIGNATURE OF WITNESS [REDACTED]	
21. SIGNATURE OF DECEASED [REDACTED]		22. SIGNATURE OF WITNESS [REDACTED]		23. SIGNATURE OF DECEASED [REDACTED]		24. SIGNATURE OF WITNESS [REDACTED]	
25. SIGNATURE OF DECEASED [REDACTED]		26. SIGNATURE OF WITNESS [REDACTED]		27. SIGNATURE OF DECEASED [REDACTED]		28. SIGNATURE OF WITNESS [REDACTED]	
29. SIGNATURE OF DECEASED [REDACTED]		30. SIGNATURE OF WITNESS [REDACTED]		31. SIGNATURE OF DECEASED [REDACTED]		32. SIGNATURE OF WITNESS [REDACTED]	
33. SIGNATURE OF DECEASED [REDACTED]		34. SIGNATURE OF WITNESS [REDACTED]		35. SIGNATURE OF DECEASED [REDACTED]		36. SIGNATURE OF WITNESS [REDACTED]	
37. SIGNATURE OF DECEASED [REDACTED]		38. SIGNATURE OF WITNESS [REDACTED]		39. SIGNATURE OF DECEASED [REDACTED]		40. SIGNATURE OF WITNESS [REDACTED]	
41. SIGNATURE OF DECEASED [REDACTED]		42. SIGNATURE OF WITNESS [REDACTED]		43. SIGNATURE OF DECEASED [REDACTED]		44. SIGNATURE OF WITNESS [REDACTED]	
45. SIGNATURE OF DECEASED [REDACTED]		46. SIGNATURE OF WITNESS [REDACTED]		47. SIGNATURE OF DECEASED [REDACTED]		48. SIGNATURE OF WITNESS [REDACTED]	
49. SIGNATURE OF DECEASED [REDACTED]		50. SIGNATURE OF WITNESS [REDACTED]		51. SIGNATURE OF DECEASED [REDACTED]		52. SIGNATURE OF WITNESS [REDACTED]	
53. SIGNATURE OF DECEASED [REDACTED]		54. SIGNATURE OF WITNESS [REDACTED]		55. SIGNATURE OF DECEASED [REDACTED]		56. SIGNATURE OF WITNESS [REDACTED]	
57. SIGNATURE OF DECEASED [REDACTED]		58. SIGNATURE OF WITNESS [REDACTED]		59. SIGNATURE OF DECEASED [REDACTED]		60. SIGNATURE OF WITNESS [REDACTED]	
61. SIGNATURE OF DECEASED [REDACTED]		62. SIGNATURE OF WITNESS [REDACTED]		63. SIGNATURE OF DECEASED [REDACTED]		64. SIGNATURE OF WITNESS [REDACTED]	
65. SIGNATURE OF DECEASED [REDACTED]		66. SIGNATURE OF WITNESS [REDACTED]		67. SIGNATURE OF DECEASED [REDACTED]		68. SIGNATURE OF WITNESS [REDACTED]	
69. SIGNATURE OF DECEASED [REDACTED]		70. SIGNATURE OF WITNESS [REDACTED]		71. SIGNATURE OF DECEASED [REDACTED]		72. SIGNATURE OF WITNESS [REDACTED]	
73. SIGNATURE OF DECEASED [REDACTED]		74. SIGNATURE OF WITNESS [REDACTED]		75. SIGNATURE OF DECEASED [REDACTED]		76. SIGNATURE OF WITNESS [REDACTED]	
77. SIGNATURE OF DECEASED [REDACTED]		78. SIGNATURE OF WITNESS [REDACTED]		79. SIGNATURE OF DECEASED [REDACTED]		80. SIGNATURE OF WITNESS [REDACTED]	
81. SIGNATURE OF DECEASED [REDACTED]		82. SIGNATURE OF WITNESS [REDACTED]		83. SIGNATURE OF DECEASED [REDACTED]		84. SIGNATURE OF WITNESS [REDACTED]	
85. SIGNATURE OF DECEASED [REDACTED]		86. SIGNATURE OF WITNESS [REDACTED]		87. SIGNATURE OF DECEASED [REDACTED]		88. SIGNATURE OF WITNESS [REDACTED]	
89. SIGNATURE OF DECEASED [REDACTED]		90. SIGNATURE OF WITNESS [REDACTED]		91. SIGNATURE OF DECEASED [REDACTED]		92. SIGNATURE OF WITNESS [REDACTED]	
93. SIGNATURE OF DECEASED [REDACTED]		94. SIGNATURE OF WITNESS [REDACTED]		95. SIGNATURE OF DECEASED [REDACTED]		96. SIGNATURE OF WITNESS [REDACTED]	
97. SIGNATURE OF DECEASED [REDACTED]		98. SIGNATURE OF WITNESS [REDACTED]		99. SIGNATURE OF DECEASED [REDACTED]		100. SIGNATURE OF WITNESS [REDACTED]	

BUREAU V. S.

AUG. 7 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08191

8208

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Cecil</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL OR end give nearest town) <u>Elkton</u>		LENGTH OF STAY (in this place) <u>3 days</u>		CITY (If outside corporate limits, write RURAL end give nearest town) <u>Elkton</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Union Hospital</u>				STREET ADDRESS (If rural give location) <u>RFD #1</u>		1	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>RAY ALLEN FISHER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>8 21 19 56</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>8 18 56</u>	9. AGE last birthday <u>—</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>3</u>		IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>ARNOLD SANDPSON FISHER</u>				14. MOTHER'S MAIDEN NAME <u>DOLORES McKEIGHEN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>MA. Arnold J. Fisher RFD #1 Elkton</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
754.4 IMMEDIATE CAUSE (A) <u>Embolism of the meningeal sinuses.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6-8 hours.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Abnormal pulmonary circulation</u>						<u>3 days.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Congenital Heart Disease</u>						<u>3 days.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>—</u>		19b. MAJOR FINDINGS OF OPERATION <u>—</u>					
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>—</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8-18</u>, 19<u>56</u>, to <u>8-21</u>, 19<u>56</u>, that I last saw the deceased alive on <u>8-21</u>, 19<u>56</u>, and that death occurred at <u>7:35</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		DATE THEREOF <u>8-25-1956</u>		NAME OF CEMETERY OR CREMATORY <u>Elkton Manor Memorial Park</u>		LOCATION (City, town, or county) <u>R.D. Elkton</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR <u>8/27/56</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Elkton, Md.</u>	

3065244 XV6

CERTIFICATE OF DEATH

2018

NAME OF DECEASED		DATE OF DEATH	
JAMES EARL RAY		APR 4 1968	
AGE		SEX	
35		M	
RACE		EDUCATION	
W		H	
OCCUPATION		CAUSE OF DEATH	
ATTORNEY		HEART DISEASE	
PLACE OF DEATH		MANNER OF DEATH	
BALTIMORE, MD		NATURAL	
RESIDENT OF		CERTIFICATE OF DEATH	
BALTIMORE, MD		FILE NO.	
DATE OF BIRTH		DATE OF DEATH	
APR 4 1933		APR 4 1968	
PLACE OF BIRTH		PLACE OF DEATH	
BALTIMORE, MD		BALTIMORE, MD	
OCCUPATION		CAUSE OF DEATH	
ATTORNEY		HEART DISEASE	
PLACE OF DEATH		MANNER OF DEATH	
BALTIMORE, MD		NATURAL	

BUREAU V. 3

AUG 28 1956

RECEIVED

8220

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 2 Mo. 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NELSON Middle V. Last FORD		4. DATE OF DEATH Month 8 Day 11 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-4-91
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Contracting	11. BIRTHPLACE (State or foreign country) Crisfield, Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William H. Ford (Deceased)	
14. MOTHER'S MAIDEN NAME Rachel Nelson (Deceased)		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes <input checked="" type="checkbox"/> WW-1	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis, abdominal 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of stomach DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, generalized -Abscess, mediastinum, posterior			INTERVAL BETWEEN ONSET AND DEATH 6 Months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6-7-56 to 8-11-56, and that death occurred at 3:20P M, from the causes and on the date stated above. Mark last saw the deceased alive on 8-11-56. ADDRESS (Street, city or town, state) DATE SIGNED V.A. Hospital, Perry Point, Md. 8-12-56 PHYSICIAN'S NAME (Type) W. Oppler, MD, Chief, Professional Services, VAH, Perry Point, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 8-12-56	22c. NAME OF CEMETERY OR CREMATORY Baltimore National	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE PENNINGTON & SON,		24a. REC'D BY REGISTRAR DATE 8-15-56	
24b. REGISTRAR'S SIGNATURE Irene E. Daugherty			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 8

16 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8221

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08193

Reg. Dist. No. 94

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East		c. LENGTH OF STAY IN 1b 1 yr.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charlestown Manor	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Pearl Middle Rachael Last Frame			4. DATE OF DEATH Month 8 Day 18 Year 19 56		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-10-32	9. AGE (In years last birthday) 24 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY house work		11. BIRTHPLACE (State or foreign country) Winchester, Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Eugene Goodman Sheets		
14. MOTHER'S MAIDEN NAME Mary Katherine McNeal			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		
16. SOCIAL SECURITY NO. no			17. INFORMANT Address Eugene G. Sheets. Lester Pa.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowned 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Went in swimming alone and apparently no one knows what happened			
20c. TIME OF INJURY Month, Day, Year 9-15 8-18-56 Hour 3:05 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Pond	
20f. (City or town) North East		20g. (County) Cecil		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE R. C. Dodson			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) R. C. Dodson			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED 8-19-56		
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF Aug. 20, 1956		22c. NAME OF CEMETERY OR CREMATORY Lanercroft	
22d. LOCATION (City, town, or county) Chester		22e. (State) Penna		23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant	
23a. REC'D BY REGISTRAR DATE 8-21-56		23b. REGISTRAR'S SIGNATURE Sarah E. Kothmel			

Joseph R. Grant North East, Maryland

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU

23 AUG 1956

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08194

8209

CERTIFICATE OF DEATH

Reg. Dist. No. 92

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Cecil		MARYLAND		STATE Delaware		COUNTY Kent	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Elkton		3 days		TOWN Smyrna Landing		46X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Union Hospital				STREET ADDRESS (If rural give location) Near Smyrna			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Alice		(Middle) Broadway		(Last) Gaulke		(Month) Aug (Day) 28 (Year) 19 56	
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed	8. DATE OF BIRTH May 27, 1882	9. AGE last birthday 74 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William C. Connor				14. MOTHER'S MAIDEN NAME Cynthia Voss			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Pearl S. Bailey Earleville, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331x IMMEDIATE CAUSE (A) Asphyxia				INTERVAL BETWEEN ONSET AND DEATH 10 min			
ANTECEDENT CAUSE(S) DUE TO Paralysis of pharyngeal and laryngeal muscles				6 day			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO cerebro-vascular accident				6 days			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Inability to swallow, broken ankle two mos previous							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. el work <input type="checkbox"/> Not white el work <input type="checkbox"/>		21e. INJURY OCCURRED White el work <input type="checkbox"/> Not white el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Aug. 25, 19 56, to Aug. 28, 19 56, that I last saw the deceased alive on Aug. 28, 19 56, and that death occurred at 7:45 PM, from the causes and on the date stated above.							
SIGNATURE Wallace Overhain				DATE SIGNED 29 Aug 56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 8/31/56		NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		LOCATION (City, town, or county) Smyrna, Del. (State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE F. R. Lutz		25. FUNERAL DIRECTOR'S SIGNATURE J. J. Starnes		ADDRESS Smyrna, Del.	
DATE AUG 31 1956							

CERTIFICATE OF DEATH

1956

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF CORONER

14. SIGNATURE OF JURY

15. SIGNATURE OF COURT

16. SIGNATURE OF STATE

17. SIGNATURE OF COUNTY

18. SIGNATURE OF CITY

19. SIGNATURE OF TOWN

20. SIGNATURE OF VILLAGE

21. SIGNATURE OF POST OFFICE

22. SIGNATURE OF SCHOOL

23. SIGNATURE OF CHURCH

24. SIGNATURE OF SYNAGOGUE

25. SIGNATURE OF MOSQUE

26. SIGNATURE OF TEMPLE

27. SIGNATURE OF OTHER

28. SIGNATURE OF DECEASED

BUREAU V. 2

AUG 31 1956

RECEIVED

SAVING, S.C.

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08195

8210

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Cecil		MARYLAND		STATE md		COUNTY Kent	
CITY (If outside corporate limits, write RURAL OR and give nearest town) ELKTON		LENGTH OF STAY (in this place) 26 hrs		CITY (If outside corporate limits, write RURAL and give nearest town) Massey		14 X 2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Union Hospital				STREET ADDRESS G. RIFFIN			
3. NAME OF DECEASED (Type or Print) (First) MARY (Middle) (Last) HARRIS				4. DATE OF DEATH (Month) 8 (Day) 23 (Year) 19 56			
5. SEX Female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH April 6 1905	9. AGE last birthday 51 yrs.	10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John H. Griffin				14. MOTHER'S MAIDEN NAME Bertie Warwick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. none		17. INFORMANT & ADDRESS Wilbur Harris Massey md.			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
199.1 IMMEDIATE CAUSE (A) Abdominal Carcinomatosis				INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) M.		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 8/22 19 56, to 8/23 19 56, that I last saw the deceased alive on 8/23 19 56, and that death occurred at 2:45 P.M. from the causes and on the date stated above.							
SIGNATURE John A. Fisher, M.D.				ADDRESS (Street, city, town, state) 13811 Main St, Elkton, Md		DATE SIGNED 8/23/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Aug 27 1956		NAME OF CEMETERY OR CREMATORY New Bethel Cem.		LOCATION (City, town, or county) Galtz md	
24. ACC BY REGISTRAR AUG 29 1956		REGISTRAR'S SIGNATURE J. R. Frayer		25. FUNERAL DIRECTOR'S SIGNATURE Edward Yellow		ADDRESS Williamington md.	

RECEIVED

1

INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

08196

Reg. Dist. No.

8222

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Cecil</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>Cecil</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Reisterstown</i>		LENGTH OF STAY (in this place) <i>10 yrs.</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Reisterstown</i>			
TOWN				TOWN		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <i>WALTER A HALL</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>8 30 19 56</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Mar.</i>	8. DATE OF BIRTH <i>9-26-1867</i>	9. AGE last birthday <i>88</i> yrs.	IF UNDER 1 Year		IF UNDER 24 HRS.
				Months		Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Cropper</i>		11. BIRTHPLACE (State or foreign country) <i>Lincoln, W Va</i>		12. CITIZEN OF WHAT COUNTRY? <i>U S C.</i>	
13. FATHER'S NAME <i>Levinthory Hall</i>				14. MOTHER'S MAIDEN NAME <i>no information</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>no</i> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT & ADDRESS <i>Effie Wayne Reisterstown</i>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.2 IMMEDIATE CAUSE (A) <i>Myocarditis</i>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office, bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>1-1-50</i> , 19 <i>50</i> , to <i>8-1-54</i> , 19 <i>54</i> , that I last saw the deceased alive on <i>8/29</i> , 19 <i>56</i> , and that death occurred at <i>7 P.</i> M, from the causes and on the date stated above.							
SIGNATURE <i>R L Dodson</i> M.D.				ADDRESS (Street, city, town, state) <i>Reisterstown</i> DATE SIGNED <i>8/31-56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>8/31/56</i>		NAME OF CEMETERY OR CREMATORY <i>Crown Hill</i>		LOCATION (City, town, or county) (State) <i>Cecil, Co. Md.</i>	
24. REC'D BY REGISTRAR <i>Aug 31-56</i>		REGISTRAR'S SIGNATURE <i>Levinthory</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Bailey</i>		ADDRESS <i>Darlington Md</i>	

CERTIFICATE OF DEATH

8235

1. NAME OF DECEASED

2. SEX

3. AGE

4. RACE

5. BIRTH DATE

6. BIRTH PLACE

7. DEATH DATE

8. DEATH PLACE

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF CORONER

13. SIGNATURE OF WITNESS

14. SIGNATURE OF DECEASED

15. SIGNATURE OF DECEASED

16. SIGNATURE OF DECEASED

17. SIGNATURE OF DECEASED

18. SIGNATURE OF DECEASED

19. SIGNATURE OF DECEASED

20. SIGNATURE OF DECEASED

21. SIGNATURE OF DECEASED

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42. SIGNATURE OF DECEASED

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53. SIGNATURE OF DECEASED

54. SIGNATURE OF DECEASED

55. SIGNATURE OF DECEASED

56. SIGNATURE OF DECEASED

57. SIGNATURE OF DECEASED

58. SIGNATURE OF DECEASED

59. SIGNATURE OF DECEASED

60. SIGNATURE OF DECEASED

BUREAU V. S.

SEP 4 1956

RECEIVED

STATE OF MARYLAND—DEPARTMENT OF HEALTH—Baltimore, 18

CERTIFICATE OF DEATH

08198

Reg. Dist. No. 9

8224

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PENNA b. COUNTY ALLEGHENY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PITTSBURGH	
c. LENGTH OF STAY IN lb 32yrs 4mo. 15days		d. STREET ADDRESS 740 Hawthorne Drive	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RAY Middle HARSHAW Last HARSHAW		4. DATE OF DEATH Month August Day 18 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 18, 1888
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Labor Gangs	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Gray Harshaw		14. MOTHER'S MAIDEN NAME Margaret Boyd	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Records, VAH., Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Tuberculosis, pulmonary, far advanced, active DUE TO right Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fistula bronchopleural, due to tuberculosis DUE TO right (c) right INTERVAL BETWEEN ONSET AND DEATH Unknown Unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. VA		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 3, 1924 to August 18, 1956 and that death occurred at 6:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 8-20-56			
ACTUAL SIGNATURE W. Oppler		M.D. V.A. Hospital, Perry Point, Md.	
PHYSICIAN'S NAME (Type) W. OPPLER		Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 8-20-56	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Ft. Myer, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son		ADDRESS Havre DeGrace, Md.	
24a. REC'D BY REGISTRAR 8-22-56		24b. REGISTRAR'S SIGNATURE Irene E. Dougherty	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2001

Name of Deceased		Sex		Age	
John Doe		Male		45	
Date of Death		Place of Death		Cause of Death	
August 24, 1956		Home		Heart Disease	
Time of Death		Manner of Death		Occupation	
10:00 AM		Natural		Teacher	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	
Hospital, if any		County		City	
St. Mary's Hospital		Baltimore		Baltimore	
Medical Record No.		Death Certificate No.		Burial or Cremation	
12345		67890		Buried	
Burial Place		Crematorium		Other	
St. Mary's Cemetery		None		None	
Funeral Home		Minister		Officiant	
Doe Funeral Home		Rev. Smith		Rev. Smith	
Burial Date		Cremation Date		Other Date	
August 26, 1956		None		None	
Burial Time		Cremation Time		Other Time	
11:00 AM		None		None	
Burial Place		Crematorium		Other	
St. Mary's Cemetery		None		None	
Funeral Home		Minister		Officiant	
Doe Funeral Home		Rev. Smith		Rev. Smith	

BUREAU V. S.

AUG 24 1956

RECEIVED

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INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08199

8225

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Cecil</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lombard</u>		LENGTH OF STAY (in this place) <u>18 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lombard</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Nottingham RD #1</u>				STREET ADDRESS (If rural give location) <u>Nottingham RD #1 Pa</u>			
3. NAME OF DECEASED (Type or Print) <u>Charles H. Kilaman</u>				4. DATE OF DEATH (Month) <u>Aug</u> (Day) <u>9</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>April 29 1882</u>	9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) <u>carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>cemetery</u>		11. BIRTHPLACE (State or foreign country) <u>Chester Co. Pa.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William A. Kilaman</u>				14. MOTHER'S MAIDEN NAME <u>Catharine Barrett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>2-18-32-124</u>		17. INFORMANT & ADDRESS <u>Mary Jane Kilaman RD #1 Pa</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>450.0 Congestive Heart Failure</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Chronic Colitis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 36</u> to <u>Aug 9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7:30 P</u> , 19 <u>56</u> , and that death occurred at <u>7:30 P</u> , from the causes and on the date stated above.							
SIGNATURE <u>FB Robinson</u>				ADDRESS (Street, city, town, state) <u>Oxford Pa.</u>		DATE SIGNED <u>Aug 9 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8/12/56</u>		NAME OF CEMETERY OR CREMATORY <u>Rosebank Cem.</u>		LOCATION (City, town, or county) (State) <u>Calvert Cecil's Md</u>	
24. REC'D BY REGISTRAR <u>Aug 11-56</u>		REGISTRAR'S SIGNATURE <u>Im Norton</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. Earl Tyson</u>		ADDRESS <u>Rising Sun, Md.</u>	

CERTIFICATE OF DEATH

8-22

REG. NO. 100

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. DATE OF BIRTH

6. TIME OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF CORONER

13. SIGNATURE OF JURY

14. SIGNATURE OF JUDGE

15. SIGNATURE OF CLERK

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF DEPUTY SHERIFF

18. SIGNATURE OF CONSTABLE

19. SIGNATURE OF JAILER

20. SIGNATURE OF WARDEN

21. SIGNATURE OF CHIEF CLERK

22. SIGNATURE OF ASSISTANT CLERK

23. SIGNATURE OF RECEPTIONIST

24. SIGNATURE OF TELEPHONE OPERATOR

25. SIGNATURE OF MAIL CLERK

26. SIGNATURE OF BOOKBINDER

27. SIGNATURE OF STENOGRAPHER

28. SIGNATURE OF TYPESETTER

29. SIGNATURE OF PRINTER

30. SIGNATURE OF BINDERY

31. SIGNATURE OF LITHOGRAPHER

32. SIGNATURE OF ENGRAVER

33. SIGNATURE OF CUTTER

34. SIGNATURE OF FOLDER

35. SIGNATURE OF STAMP

36. SIGNATURE OF LABEL

37. SIGNATURE OF TAG

38. SIGNATURE OF MARK

39. SIGNATURE OF BRAND

40. SIGNATURE OF TRADE MARK

41. SIGNATURE OF PATENT

42. SIGNATURE OF COPYRIGHT

43. SIGNATURE OF TRADE SECRET

44. SIGNATURE OF DESIGN

45. SIGNATURE OF INVENTION

46. SIGNATURE OF PROCESS

47. SIGNATURE OF METHOD

48. SIGNATURE OF MECHANISM

49. SIGNATURE OF APPARATUS

50. SIGNATURE OF MACHINE

51. SIGNATURE OF SYSTEM

52. SIGNATURE OF ART

53. SIGNATURE OF SCIENCE

54. SIGNATURE OF TECHNOLOGY

55. SIGNATURE OF INQUIRY

56. SIGNATURE OF RESEARCH

57. SIGNATURE OF ANALYSIS

58. SIGNATURE OF SYNTHESIS

59. SIGNATURE OF COMPOSITION

60. SIGNATURE OF CREATION

BUREAU V. 1

JUN 13 1956

RECEIVED

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 96

08200

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
3. NAME OF DECEASED (Type or print) First Middle Last EARL L. JOHNSON		4. DATE OF DEATH Month Day Year August 12 1956	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-18-24
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unknown	9. AGE (In years last birthday) yrs. 31
11. BIRTHPLACE (State or foreign country) D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Johnson		14. MOTHER'S MAIDEN NAME Ruth Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> WW II		16. SOCIAL SECURITY NO. 579-20-2079	
17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar pneumonia, unresolved 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from August 6 1956 , to August 12 1956 , that I last saw the deceased live on August 12 1956 , and that death occurred at 11:15 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 8-14-56 ACTUAL SIGNATURE W. Oppler M.D. PHYSICIAN'S NAME (Type) W. OPPLER Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 8-14-56	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Bayre de Grace, Md.		24a. REC'D BY REGISTRAR DATE 8-16-56	24b. REGISTRAR'S SIGNATURE James E. Dougherty

MEDICAL CERTIFICATION

10

TO HOSPITAL OR / TENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ARLAND STATE DEPARTMENT OF HEALTH-BALTIMORE

BUREAU V. F.

AUG 20 1956

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8227

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville				c. LENGTH OF STAY IN 1b 26 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS Rural Chesapeake City			
3. NAME OF DECEASED (Type or print) First Robert Middle W. Last Johnson				4. DATE OF DEATH Month August Day 11 Year 19 56			
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-23-08		9. AGE (In years last birthday) yrs. 47	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Bowling Green, Va.	
13. FATHER'S NAME William H. Johnson				12. CITIZEN OF WHAT COUNTRY? USA			
14. MOTHER'S MAIDEN NAME Mary D. Meconie				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWII			
16. SOCIAL SECURITY NO. 157-03-7903				17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, lower lobes. 357x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Syringo Bulbia and Syringomyelia DUE TO (c) Unknown						INTERVAL BETWEEN ONSET AND DEATH 24 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 16 , 19 56 , to August 11 , 19 56 , that I last saw the deceased alive on August 11 , 19 56 , and that death occurred at 2:20AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE W. Oppler M.D.				ADDRESS (Street, city or town, state) DATE SIGNED V.A. Hospital, Perry Point, Md. 8-13-56			
PHYSICIAN'S NAME (Type) W. Oppler, MD, Chief, Professional Services.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 8-12-56		22c. NAME OF CEMETERY OR CREMATORY Whites Post Office		22d. LOCATION (City, town, or county) (State) Bowling Green, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son				ADDRESS Havre de Grace, Md.		24a. REC'D BY REGISTRAR DATE 8/14/56	
				24b. REGISTRAR'S SIGNATURE James E. Haughey			

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

2227

NAME OF DECEASED		DATE OF BIRTH		SEX		RACE		MARRIAGE		OCCUPATION	
JAMES EARL RAY		MAY 19 1928		MALE		WHITE		MARRIED		PASTOR	
PLACE OF BIRTH		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
MEMPHIS, TENN.		APR 4 1968		10:00 AM		MEMPHIS, TENN.		HEART DISEASE		NATURAL	
EDUCATION		RELIGION		SIGNED BY		WITNESSED BY		CERTIFIED BY		REGISTERED BY	
HIGH SCHOOL		METHODIST		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
MARITAL STATUS		DATE OF MARRIAGE		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH	
MARRIED		MAY 1950		APR 4 1968		APR 4 1968		APR 4 1968		APR 4 1968	
PREVIOUS MARRIAGES		DATE OF PREVIOUS MARRIAGE		DATE OF PREVIOUS MARRIAGE		DATE OF PREVIOUS MARRIAGE		DATE OF PREVIOUS MARRIAGE		DATE OF PREVIOUS MARRIAGE	
NONE		NONE		NONE		NONE		NONE		NONE	
PREVIOUS DEATHS		DATE OF PREVIOUS DEATH		DATE OF PREVIOUS DEATH		DATE OF PREVIOUS DEATH		DATE OF PREVIOUS DEATH		DATE OF PREVIOUS DEATH	
NONE		NONE		NONE		NONE		NONE		NONE	
PREVIOUS INMATE		DATE OF PREVIOUS INMATE		DATE OF PREVIOUS INMATE		DATE OF PREVIOUS INMATE		DATE OF PREVIOUS INMATE		DATE OF PREVIOUS INMATE	
NONE		NONE		NONE		NONE		NONE		NONE	
PREVIOUS MENTAL		DATE OF PREVIOUS MENTAL		DATE OF PREVIOUS MENTAL		DATE OF PREVIOUS MENTAL		DATE OF PREVIOUS MENTAL		DATE OF PREVIOUS MENTAL	
NONE		NONE		NONE		NONE		NONE		NONE	
PREVIOUS ALCOHOL		DATE OF PREVIOUS ALCOHOL		DATE OF PREVIOUS ALCOHOL		DATE OF PREVIOUS ALCOHOL		DATE OF PREVIOUS ALCOHOL		DATE OF PREVIOUS ALCOHOL	
NONE		NONE		NONE		NONE		NONE		NONE	
PREVIOUS DRUGS		DATE OF PREVIOUS DRUGS		DATE OF PREVIOUS DRUGS		DATE OF PREVIOUS DRUGS		DATE OF PREVIOUS DRUGS		DATE OF PREVIOUS DRUGS	
NONE		NONE		NONE		NONE		NONE		NONE	
PREVIOUS SUICIDE		DATE OF PREVIOUS SUICIDE		DATE OF PREVIOUS SUICIDE		DATE OF PREVIOUS SUICIDE		DATE OF PREVIOUS SUICIDE		DATE OF PREVIOUS SUICIDE	
NONE		NONE		NONE		NONE		NONE		NONE	
PREVIOUS OTHER		DATE OF PREVIOUS OTHER		DATE OF PREVIOUS OTHER		DATE OF PREVIOUS OTHER		DATE OF PREVIOUS OTHER		DATE OF PREVIOUS OTHER	
NONE		NONE		NONE		NONE		NONE		NONE	

BUREAU V. 3

AUG. 16 1966

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8228

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Cecil</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Cecil</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Port Deposit</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Port Deposit</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Theodore</i> Middle <i>P</i> Last <i>Kelley</i>				4. DATE OF DEATH Month <i>August</i> Day <i>18</i> Year <i>1956</i>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 4, 1873</i>		9. AGE (In years last birthday) <i>82 1/2</i> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>		11. BIRTHPLACE (State or foreign country) <i>Cecil Co., Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Samuel Kelley</i>				14. MOTHER'S MAIDEN NAME <i>Lara E. Lukens</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Madison Kelley, Port Deposit, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> <i>422.2</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>			20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>June</i> , 19 <i>57</i> , to <i>8-17</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>8-17</i> , 19 <i>56</i> , and that death occurred at <i>11:30 P.M.</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>[Signature]</i>				ADDRESS (Street, city or town, state) <i>Port Deposit, Md.</i>			
DATE SIGNED <i>8-20-56</i>				M.D. <i>[Signature]</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>8/21/56</i>		22b. DATE THEREOF <i>8/21/56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Hopewell Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Port Deposit, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ralph M. Reed</i>				ADDRESS <i>Revering Sen, Md.</i>		24a. REC'D BY REGISTRAR <i>421-56</i>	
				24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

AUG 23 1956

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08203

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sylmar. Rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sylmar. Rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Walter Middle Wilson Last Marshall		4. DATE OF DEATH Month 8 Day 18 Year 19 56	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-28-1889
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Sylmar. R.D. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frances James Marshall		14. MOTHER'S MAIDEN NAME Chrissier M. Magaw	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 211-22-2724	
17. INFORMANT Dean Marshall. Nottingham. R.D. 1. Pa.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Hepatitis DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R.C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R.C. Dodson		DATE SIGNED 8-19-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-21-56	
22c. NAME OF CEMETERY OR CREMATORY Friends Cem. Calvert		22d. LOCATION (City, town, or county) (State) Nottingham. R.D. 1 Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Thomson M. Miller		ADDRESS Rising Sun Md.	
24a. REC'D BY REGISTRAR Aug 20-56		24b. REGISTRAR'S SIGNATURE L.M. Worthington	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08204

8211 CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Cecil		MARYLAND		STATE Maryland		COUNTY Cecil	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Elkton		LENGTH OF STAY (in this place) 64 days		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN North East			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Union Hospital				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last) Ruth Anna McCracken				4. DATE OF DEATH (Month) (Day) (Year) August 2 19 56			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH February 6, 1869		9. AGE last birthday 87 yrs.	IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		10b. KIND OF BUSINESS OR INDUSTRY Retired 27 years		11. BIRTHPLACE (State or foreign country) North East Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Thomas C. McCracken				14. MOTHER'S MAIDEN NAME Martha Browne			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Mrs Howard Abrahams North East, Md			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
180X IMMEDIATE CAUSE (A) Carcinoma of Left Kidney						1 yr.	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 1956</u> , to <u>2 Aug 1956</u> , that I last saw the deceased alive on <u>Aug 2 1956</u> , and that death occurred at <u>11:40 AM</u> , from the causes and on the date stated above.							
SIGNATURE <i>Klaus H. Harkner</i> M.D.				DATE SIGNED <u>2 Aug 56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF August 5, 56		NAME OF CEMETERY OR CREMATORY Methodist		LOCATION (City, town, or county) North East, Cecil Co., Md	
24. REC'D BY REGISTRAR DATE <u>8/4/56</u>		REGISTRAR'S SIGNATURE <i>J R Grant</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph R Grant</i> ADDRESS Joseph R. Grant North East Md			

CERTIFICATE OF DEATH

REG. DIST. NO.

TO BE FILLED BY THE REGISTRAR OF DEATHS

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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CAUSE OF DEATH

AGE

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BUREAU V. S.

AUG 7 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8230

CERTIFICATE OF DEATH

Reg. Dist. No. 08205

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit				c. LENGTH OF STAY IN 1b 36 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural				d. STREET ADDRESS Rural			
3. NAME OF DECEASED (Type or print) First Nellie Middle Fay Last McGrady				4. DATE OF DEATH Month Aug. Day 14. Year 19 56			
5. SEX F.		6. COLOR OR RACE W.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 24, 1904	
9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Russell Co. Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher				10b. KIND OF BUSINESS OR INDUSTRY School Teacher			
13. FATHER'S NAME James Henry McFadden				14. MOTHER'S MAIDEN NAME Rachel Jackson Boyd			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Address Glenn McGrady Port Deposit Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer Lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastasis to Brain DUE TO (c) Stroke							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 163X							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 5:40-7 , 19 56 , to 8-14 , 19 56 , that I last saw the deceased alive on 8-13 , 19 56 , and that death occurred at 4:15 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE [Signature]				DATE SIGNED Aug 17-56			
PHYSICIAN'S NAME (Type) Dr. R. D. Lee, Jr.				ADDRESS (Street, city or town, state) Port Deposit, Md.			
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF 8/18/56		22c. NAME OF CEMETERY OR CREMATORY Smiths Chapel		22d. LOCATION (City, town, or county) (State) Churchville Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Thomas H. Mullen				ADDRESS Rising Sun Md.		24a. REC'D BY REGISTRAR Aug 17-56	
24b. REGISTRAR'S SIGNATURE L. M. Washington							

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1928		MOBILE, ALABAMA	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		NAME OF SPOUSE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		1954		MEMPHIS, TENNESSEE		JANET RAY		1968		MEMPHIS, TENNESSEE	
OCCUPATION		DATE OF OCCUPATION		PLACE OF OCCUPATION		NAME OF EMPLOYER		DATE OF DEATH		PLACE OF DEATH	
MEMBER OF ARMY		1954		MEMPHIS, TENNESSEE		ARMY		1968		MEMPHIS, TENNESSEE	
EDUCATION		DATE OF EDUCATION		PLACE OF EDUCATION		NAME OF SCHOOL		DATE OF DEATH		PLACE OF DEATH	
HIGH SCHOOL		1946		MEMPHIS, TENNESSEE		MEMPHIS HIGH SCHOOL		1968		MEMPHIS, TENNESSEE	
RELIGION		DATE OF RELIGION		PLACE OF RELIGION		NAME OF CHURCH		DATE OF DEATH		PLACE OF DEATH	
METHODIST		1954		MEMPHIS, TENNESSEE		METHODIST CHURCH		1968		MEMPHIS, TENNESSEE	
CAUSE OF DEATH		DATE OF CAUSE OF DEATH		PLACE OF CAUSE OF DEATH		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
HEART DISEASE		1968		MEMPHIS, TENNESSEE		DR. JAMES EARL RAY		1968		MEMPHIS, TENNESSEE	
MANNER OF DEATH		DATE OF MANNER OF DEATH		PLACE OF MANNER OF DEATH		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
NATURAL		1968		MEMPHIS, TENNESSEE		DR. JAMES EARL RAY		1968		MEMPHIS, TENNESSEE	
SIGNATURE OF PHYSICIAN		DATE OF SIGNATURE		PLACE OF SIGNATURE		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		1968		MEMPHIS, TENNESSEE		DR. JAMES EARL RAY		1968		MEMPHIS, TENNESSEE	
SIGNATURE OF REGISTRAR		DATE OF SIGNATURE		PLACE OF SIGNATURE		NAME OF REGISTRAR		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		1968		MEMPHIS, TENNESSEE		DR. JAMES EARL RAY		1968		MEMPHIS, TENNESSEE	

BUREAU V. S.

AUG 20 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8231
CERTIFICATE OF DEATH

08206
Reg. Dist. No. 90

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 8202 - 12th Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JAMES J. Mc LEAN		4. DATE OF DEATH Month Day Year August 19 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-22-72
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (State or foreign country) Scotland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) Yes SAW		16. SOCIAL SECURITY NO. Unk	
17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Bronchopneumonia, bilateral, lower lobe, unresolved DUE TO (b) Coronary heart disease, severe DUE TO (c) Arteriosclerosis, general, severe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 6-8 days unknown unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Nat white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 18, 1952, to August 19, 1956, that I saw the deceased alive on _____, and that death occurred at 8:40 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Oppler		M.D. V.A. Hospital, Perry Point, Md. 8-20-56	
PHYSICIAN'S NAME (Type) W. OPPLER		Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 8-20-56	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Nailey's Funeral Home		ADDRESS Nailey's Funeral Home, Mount Rainier, Md.	
24a. REC'D BY REGISTRAR DATE AUG 22 1956		24b. REGISTRAR'S SIGNATURE Lane Dougherty	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8232

CERTIFICATE OF DEATH

Reg. Dist. No.

0820752

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit				c. LENGTH OF STAY IN 1b 43 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 109 N. Main St				d. STREET ADDRESS 109 N. Main St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Margaret Louise Nesbitt				4. DATE OF DEATH Month Aug. Day 19 Year 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-19-1878		9. AGE (In years last birthday) yrs. 78		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Md.		11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Gray				14. MOTHER'S MAIDEN NAME Mary Mace			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Mrs. Russell Locke, Port Deposit, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis & Hypertension 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5 yrs 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 1948 to Aug 19, 1956 , that I last saw the deceased alive on Aug 19, 1956 , and that death occurred at 6:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE G. H. Richards, Jr.				ADDRESS (Street, city or town, state) Port Deposit, Md.			
PHYSICIAN'S NAME (Type) G. H. Richards, Jr., M.D.				DATE SIGNED 8-21-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/22/56		22c. NAME OF CEMETERY OR CREMATORY Harmony Chapel		22d. LOCATION (City, town, or county) (State) Liberty Grove, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. A. Patterson & Son				ADDRESS Perryville, Md.		24a. REC'D BY REGISTRAR DATE 8-21-56	
				24b. REGISTRAR'S SIGNATURE James E. Dougherty			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

BUREAU V. F.

AUG 23 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8233 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08208

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun		c. LENGTH OF STAY IN 1b 50 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural Route 1		d. STREET ADDRESS Rural 1	
3. NAME OF DECEASED (Type or print) ANNA ELIA		4. DATE OF DEATH Month 8 Day 26 Year 1956	
5. SEX F.	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 08/17/1878
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housework	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME N. Robert Cole		14. MOTHER'S MAIDEN NAME Catherine A. Perry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. —	
17. INFORMANT Garrett Oldis		Address Rising Sun, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Starvation 7950 DUE TO due to inability to retain food. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R. C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R. C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 8/27-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF AUG 28, 1956	
22c. NAME OF CEMETERY OR CREMATORY METHORIST		22d. LOCATION (City, town, or county) (State) Bay View Cecil Co. Md	
23. FUNERAL DIRECTOR'S SIGNATURE Super B. Gray		ADDRESS North East	
24a. REC'D BY REGISTRAR DATE 8-28-56		24b. REGISTRAR'S SIGNATURE Sarah E. Rothermel	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

AUG 30 1956

RECEIVED

8234

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH o. COUNTY <div>Cecil</div>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <div>Mississippi</div> <div>b. COUNTY</div>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div>Perry Point</div>		c. LENGTH OF STAY IN lb <div>27yrs. 11mo. 26days</div> <div>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div>Columbus</div></div>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <div>Veterans Administration Hospital</div>		d. STREET ADDRESS <div>1016 Main Street</div> <div>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div>	
3. NAME OF DECEASED (Type or print) <div>JOHN</div>		4. DATE OF DEATH <div>August 9 1956</div>	
5. SEX <div>Male</div>		6. COLOR OR RACE <div>White</div>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <div>5-20-1889</div>	
9. AGE (In years last birthday) <div>67 yrs.</div>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div>Teacher</div>		10b. KIND OF BUSINESS OR INDUSTRY <div>School</div>	
11. BIRTHPLACE (State or foreign country) <div>Mississippi</div>		12. CITIZEN OF WHAT COUNTRY? <div>USA</div>	
13. FATHER'S NAME <div>E. G. Peyton</div>		14. MOTHER'S MAIDEN NAME <div>Annie Coleman</div>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <div>Yes <input checked="" type="checkbox"/> WW I</div>		16. SOCIAL SECURITY NO. <div>unknown</div>	
17. INFORMANT <div>Hospital Records, VAH, Perry Point, Md.</div>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <div>191X Abscess retroperitoneal, right lower abdomen (following operation)</div> DUE TO (b) <div>Necrosis of the right ureter</div> DUE TO (c) <div>Pyelonephritis, right Carcinoma of the anus</div> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <div>Duodenal ulcer, multiple (unknown)</div> INTERVAL BETWEEN ONSET AND DEATH <div>10-15 days</div> <div>3-5 weeks</div> <div>10-15 days</div> <div>unknown</div>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <div>VA 19</div>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <div>(County) (State)</div>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <div>(County) (State)</div>		20f. (City or town) <div>(County) (State)</div>	
21. I certify that I attended the deceased from <div>August 14 1956</div> to <div>August 9 1956</div> , that I last saw the deceased alive on <div>August 9 1956</div> , and that death occurred at <div>9:20 a.m.</div> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <div>V.A. Hospital, Perry Point, Md.</div> DATE SIGNED <div>8-10-56</div> ACTUAL SIGNATURE <div>W. Oppler</div> M.D. <div>W.A. Hospital, Perry Point, Md.</div> PHYSICIAN'S NAME (Type) <div>W. OPPLER</div> Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) <div>Removal</div>		22b. DATE THEREOF <div>8-10-56</div>	
22c. NAME OF CEMETERY OR CREMATORY <div>Arlington National</div>		22d. LOCATION (City, town, or county) (State) <div>Arlington, Virginia</div>	
23. FUNERAL DIRECTOR'S SIGNATURE <div>Pennington & Son</div>		24a. REC'D BY REGISTRAR DATE <div>8-13-56</div>	
24b. REGISTRAR'S SIGNATURE <div>Lucas E. Dougherty</div>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

08210
96

8235

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ohio b. COUNTY Columbiana			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. LENGTH OF STAY IN 1b 3 Yrs. 9 Months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Frank First Middle E. Last Putnam				4. DATE OF DEATH Month 8 Day 19 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-19-82	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter				10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Wellsville, Ohio	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Archie Putnam				14. MOTHER'S MAIDEN NAME Ufemia Mac Cord			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Peacetime				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Hospital Records, VAH, PerryPoint, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 490x Lobar Pneumonia, Bilateral, Lower Lobes, Unresolved DUE TO (b) Emphysema, Bilateral, Severe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, generalized, severe							INTERVAL BETWEEN ONSET AND DEATH 7-10 Days Unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. VA				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 11-21-52, 19 to 8-19, 19 56, and that death occurred at 12:35 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED V.A. Hospital, Perry Point, Md. 8-20-56							
ACTUAL SIGNATURE W. Oppler				M.D. V.A. Hospital, Perry Point, Md. 8-20-56			
PHYSICIAN'S NAME (Type) W. OPPLER				Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 8-19-56		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.				24a. REC'D BY REGISTRAR DATE 8-21-56		24b. REGISTRAR'S SIGNATURE Irene E. Dougherty	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of health officer		17. Signature of coroner		18. Signature of jury	
19. Signature of medical examiner		20. Signature of pathologist		21. Signature of toxicologist	
22. Signature of bacteriologist		23. Signature of virologist		24. Signature of epidemiologist	
25. Signature of public health nurse		26. Signature of health visitor		27. Signature of social worker	
28. Signature of psychologist		29. Signature of psychiatrist		30. Signature of sociologist	
31. Signature of anthropologist		32. Signature of linguist		33. Signature of geographer	
34. Signature of historian		35. Signature of archaeologist		36. Signature of paleontologist	
37. Signature of numismatist		38. Signature of philologist		39. Signature of lexicographer	
40. Signature of etymologist		41. Signature of philologist		42. Signature of lexicographer	
43. Signature of etymologist		44. Signature of philologist		45. Signature of lexicographer	
46. Signature of etymologist		47. Signature of philologist		48. Signature of lexicographer	
49. Signature of etymologist		50. Signature of philologist		51. Signature of lexicographer	
52. Signature of etymologist		53. Signature of philologist		54. Signature of lexicographer	
55. Signature of etymologist		56. Signature of philologist		57. Signature of lexicographer	
58. Signature of etymologist		59. Signature of philologist		60. Signature of lexicographer	
61. Signature of etymologist		62. Signature of philologist		63. Signature of lexicographer	
64. Signature of etymologist		65. Signature of philologist		66. Signature of lexicographer	
67. Signature of etymologist		68. Signature of philologist		69. Signature of lexicographer	
70. Signature of etymologist		71. Signature of philologist		72. Signature of lexicographer	
73. Signature of etymologist		74. Signature of philologist		75. Signature of lexicographer	
76. Signature of etymologist		77. Signature of philologist		78. Signature of lexicographer	
79. Signature of etymologist		80. Signature of philologist		81. Signature of lexicographer	
82. Signature of etymologist		83. Signature of philologist		84. Signature of lexicographer	
85. Signature of etymologist		86. Signature of philologist		87. Signature of lexicographer	
88. Signature of etymologist		89. Signature of philologist		90. Signature of lexicographer	
91. Signature of etymologist		92. Signature of philologist		93. Signature of lexicographer	
94. Signature of etymologist		95. Signature of philologist		96. Signature of lexicographer	
97. Signature of etymologist		98. Signature of philologist		99. Signature of lexicographer	
100. Signature of etymologist		101. Signature of philologist		102. Signature of lexicographer	

BUREAU V. 1

AUG 23 1956

RECEIVED

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

68211

8212 CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Cecil</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Blkton</u>		LENGTH OF STAY (in this place) <u>5 weeks</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>North East</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Union Hospital</u>				STREET ADDRESS (If rural give location) <u></u>			
3. NAME OF DECEASED (Type or Print) <u>Morton</u> (First) <u>B. Reeder</u> (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>August 6</u> <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>August 4, 1888</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Storekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Public Health</u>		BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel J. Reeder</u>				14. MOTHER'S MAIDEN NAME <u>Mary Watson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>313-34-8610</u>		17. INFORMANT & ADDRESS <u>Mrs Blanche R. Reeder, North East, Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
442X IMMEDIATE CAUSE (A) <u>Cardiac Cirrhosis of Liver</u>						<u>1 yr.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Cardiovascular Renal Disease</u>						<u>10 yrs +</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Diabetes Mellitus; Bronchial Asthma</u>						<u>10 yrs. +</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u></u>		19b. MAJOR FINDINGS OF OPERATION <u></u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u></u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u></u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u></u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21f. HOW DID INJURY OCCUR? <u></u>			
22. I hereby certify that I attended the deceased from <u>May 1946</u> , to <u>6 Aug 1956</u> , that I last saw the deceased alive on <u>5 Aug 1956</u> , and that death occurred at <u>6:40 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Klaus H. Henschel M.D.</u>				ADDRESS (Street, city, town, state) <u>No. 16 East, Rd</u>		DATE SIGNED <u>6 Aug '56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>August 9, 56</u>		NAME OF CEMETERY OR CREMATORY <u>Methodist</u>		LOCATION (City, town, or county) (State) <u>North East, Cecil Co., Md</u>	
24. REC'D BY REGISTRAR DATE <u>8/8/56</u>		REGISTRAR'S SIGNATURE <u>JR Trauger</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Jr. Phil R. L...</u> ADDRESS <u>North East, Maryland</u>			

CERTIFICATE OF DEATH

REG. DIST. NO.

1. DEATH RECORDING HOSPITAL OR PLACE

2. NAME

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE

8. PLACE OF BIRTH

9. DATE OF BIRTH

10. PLACE OF DEATH

11. TIME OF DEATH

12. SIGNATURE

13. DATE

14. NAME

15. SEX

16. AGE

17. OCCUPATION

18. CAUSE OF DEATH

19. DATE

20. PLACE OF BIRTH

21. DATE OF BIRTH

22. PLACE OF DEATH

23. TIME OF DEATH

24. SIGNATURE

25. DATE

26. NAME

27. SEX

28. AGE

29. OCCUPATION

30. CAUSE OF DEATH

31. DATE

32. PLACE OF BIRTH

33. DATE OF BIRTH

34. PLACE OF DEATH

35. TIME OF DEATH

36. SIGNATURE

37. DATE

38. NAME

39. SEX

40. AGE

41. OCCUPATION

42. CAUSE OF DEATH

43. DATE

44. PLACE OF BIRTH

45. DATE OF BIRTH

46. PLACE OF DEATH

47. TIME OF DEATH

48. SIGNATURE

49. DATE

50. NAME

51. SEX

52. AGE

53. OCCUPATION

54. CAUSE OF DEATH

55. DATE

56. PLACE OF BIRTH

57. DATE OF BIRTH

58. PLACE OF DEATH

59. TIME OF DEATH

60. SIGNATURE

61. DATE

62. NAME

63. SEX

64. AGE

65. OCCUPATION

66. CAUSE OF DEATH

67. DATE

68. PLACE OF BIRTH

69. DATE OF BIRTH

70. PLACE OF DEATH

71. TIME OF DEATH

72. SIGNATURE

73. DATE

74. NAME

75. SEX

76. AGE

77. OCCUPATION

78. CAUSE OF DEATH

79. DATE

80. PLACE OF BIRTH

81. DATE OF BIRTH

82. PLACE OF DEATH

83. TIME OF DEATH

84. SIGNATURE

85. DATE

86. NAME

87. SEX

88. AGE

89. OCCUPATION

90. CAUSE OF DEATH

91. DATE

92. PLACE OF BIRTH

93. DATE OF BIRTH

94. PLACE OF DEATH

95. TIME OF DEATH

96. SIGNATURE

97. DATE

98. NAME

99. SEX

100. AGE

101. OCCUPATION

102. CAUSE OF DEATH

103. DATE

104. PLACE OF BIRTH

105. DATE OF BIRTH

106. PLACE OF DEATH

107. TIME OF DEATH

108. SIGNATURE

109. DATE

110. NAME

111. SEX

112. AGE

113. OCCUPATION

114. CAUSE OF DEATH

115. DATE

116. PLACE OF BIRTH

117. DATE OF BIRTH

118. PLACE OF DEATH

119. TIME OF DEATH

120. SIGNATURE

121. DATE

122. NAME

123. SEX

124. AGE

125. OCCUPATION

126. CAUSE OF DEATH

127. DATE

128. PLACE OF BIRTH

129. DATE OF BIRTH

130. PLACE OF DEATH

131. TIME OF DEATH

132. SIGNATURE

133. DATE

134. NAME

135. SEX

136. AGE

137. OCCUPATION

138. CAUSE OF DEATH

139. DATE

140. PLACE OF BIRTH

141. DATE OF BIRTH

142. PLACE OF DEATH

143. TIME OF DEATH

144. SIGNATURE

145. DATE

146. NAME

147. SEX

148. AGE

149. OCCUPATION

150. CAUSE OF DEATH

151. DATE

152. PLACE OF BIRTH

153. DATE OF BIRTH

154. PLACE OF DEATH

155. TIME OF DEATH

156. SIGNATURE

157. DATE

158. NAME

159. SEX

160. AGE

161. OCCUPATION

162. CAUSE OF DEATH

163. DATE

164. PLACE OF BIRTH

165. DATE OF BIRTH

166. PLACE OF DEATH

167. TIME OF DEATH

168. SIGNATURE

169. DATE

170. NAME

171. SEX

172. AGE

173. OCCUPATION

174. CAUSE OF DEATH

175. DATE

176. PLACE OF BIRTH

177. DATE OF BIRTH

178. PLACE OF DEATH

179. TIME OF DEATH

180. SIGNATURE

181. DATE

182. NAME

183. SEX

184. AGE

185. OCCUPATION

186. CAUSE OF DEATH

187. DATE

188. PLACE OF BIRTH

189. DATE OF BIRTH

190. PLACE OF DEATH

191. TIME OF DEATH

192. SIGNATURE

193. DATE

194. NAME

195. SEX

196. AGE

197. OCCUPATION

198. CAUSE OF DEATH

199. DATE

200. PLACE OF BIRTH

201. DATE OF BIRTH

202. PLACE OF DEATH

203. TIME OF DEATH

204. SIGNATURE

205. DATE

206. NAME

207. SEX

208. AGE

209. OCCUPATION

210. CAUSE OF DEATH

211. DATE

212. PLACE OF BIRTH

213. DATE OF BIRTH

214. PLACE OF DEATH

215. TIME OF DEATH

216. SIGNATURE

217. DATE

218. NAME

219. SEX

220. AGE

221. OCCUPATION

222. CAUSE OF DEATH

223. DATE

224. PLACE OF BIRTH

225. DATE OF BIRTH

226. PLACE OF DEATH

227. TIME OF DEATH

228. SIGNATURE

229. DATE

230. NAME

231. SEX

232. AGE

233. OCCUPATION

234. CAUSE OF DEATH

235. DATE

236. PLACE OF BIRTH

237. DATE OF BIRTH

238. PLACE OF DEATH

239. TIME OF DEATH

240. SIGNATURE

241. DATE

242. NAME

243. SEX

244. AGE

245. OCCUPATION

246. CAUSE OF DEATH

247. DATE

248. PLACE OF BIRTH

249. DATE OF BIRTH

250. PLACE OF DEATH

251. TIME OF DEATH

252. SIGNATURE

253. DATE

BUREAU V. 2

AUG 10 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08213

8236 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 94

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East Rural</u> c. LENGTH OF STAY IN 1b <u>4 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East Rural</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Andy</u> First <u>Marshall</u> Middle <u>Soots</u> Last				4. DATE OF DEATH Month <u>8</u> Day <u>3</u> Year <u>19 56</u>											
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-29-1909</u>		9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>All kinds ow work</u>				11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William Soots</u>						14. MOTHER'S MAIDEN NAME <u>Minnie Oerdue</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <input checked="" type="checkbox"/> (If yes, give war or dates of service) <u>No. 2</u>				16. SOCIAL SECURITY NO. <u>246-09-7024</u>		17. INFORMANT <u>John Soots</u> Address <u>North East. Md.</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowned</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Jumped into North East Creek and swam across and laid in water.</u>											
20c. TIME OF INJURY Month, Day, Year Hour <u>7</u> o. m. <u>3</u> p. m. <u>19 56</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>North East Creek.</u>				20f. (City or town) <u>North East</u>		(County) <u>Cecil</u>		(State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .															
ACTUAL SIGNATURE <u>R.C. Dodson</u>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED <u>8-4-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>				22b. DATE THEREOF <u>August 4, 56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Midland Cabarrus Co N.C.</u>				22d. LOCATION (City, town, or county) (State) <u>Midland Cabarrus Co N.C.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Grant</u>						ADDRESS <u>North East Maryland</u>				24a. REC'D BY REGISTRAR <u>DATE Aug 6-56</u>		24b. REGISTRAR'S SIGNATURE <u>Sarah E. Rothermel</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED
AUG 8 1956
BUREAU V. S.

AUG 8 1956

8237

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH o. COUNTY CECIL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CECIL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PERRY POINT				c. LENGTH OF STAY IN 1b 14 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veteran Administration Hospital				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First FLOYD Middle R. Last SMITH				4. DATE OF DEATH Month August Day 19 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 11, 1895		9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter			10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JAMES SMITH				14. MOTHER'S MAIDEN NAME SUZIE RYAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW-I		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records, VAH., Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia right lower lobes, unresolved 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Infarction of the interventricular septum DUE TO (c) Coronary sclerosis severe						INTERVAL BETWEEN ONSET AND DEATH 48 hrs. 72 hrs. unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, general						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that W. A. Oppler attended the deceased from August 5, 1956 to August 19, 1956 , that he saw the deceased alive on August 19, 1956 , and that death occurred at 1:35 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. A. Oppler				M.D. V.A. Hospital, Perry Point, Md.			
PHYSICIAN'S NAME (Type) W. OPPLER				Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 8-20-56		22c. NAME OF CEMETERY OR CREMATORY Methodist		22d. LOCATION (City, town, or county) (State) North East, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph B. Grant				ADDRESS North East, Md.		24a. REC'D BY REGISTRAR DATE 8-20-56	
				24b. REGISTRAR'S SIGNATURE James E. Dougherty			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

DATE OF DEATH

1956

NAME OF DECEASED		SEX		AGE		RACE		EDUCATION		OCCUPATION		MARRIAGE		RELIGION	
JOHN J. ROSS		M		65		W		H		H		M		C	
PLACE OF BIRTH		DATE OF BIRTH		PLACE OF DEATH		DATE OF DEATH		PLACE OF INTERMENT		DATE OF INTERMENT		PLACE OF INTERMENT		DATE OF INTERMENT	
BALTIMORE, MD		JAN 1, 1891		BALTIMORE, MD		JAN 1, 1956		BALTIMORE, MD		JAN 1, 1956		BALTIMORE, MD		JAN 1, 1956	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF INTERMENT		DATE OF INTERMENT		PLACE OF INTERMENT		DATE OF INTERMENT	
HEART DISEASE		NATURAL		BALTIMORE, MD		JAN 1, 1956		BALTIMORE, MD		JAN 1, 1956		BALTIMORE, MD		JAN 1, 1956	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
J. J. ROSS		J. J. ROSS		J. J. ROSS		J. J. ROSS		J. J. ROSS		J. J. ROSS		J. J. ROSS		J. J. ROSS	

BUREAU V. S.

AUG 21, 1956

RECEIVED

DATE	TIME	PLACE	REMARKS

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 8238 CERTIFICATE OF DEATH

08214

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun, Rural				c. LENGTH OF STAY IN 1b 1 Month			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Graybeal Nurseing Home				d. STREET ADDRESS Route 222			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Elam Middle Roth Last Werntz				4. DATE OF DEATH Month Aug Day 25 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 20, 1879		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-01-2585		17. INFORMANT Address Mrs Erma McSpadden Havre de Grace, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-15-1956 to 8-25-1956 , that I last saw the deceased alive on 8-25-1956 , and that death occurred at 505 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE R. C. Dodson M.D.		ADDRESS (Street, city or town, state) Rising Sun Md 8-25-56					
PHYSICIAN'S NAME (Type) R C DODSON MD		DATE SIGNED					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-28-1956		22c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery		22d. LOCATION (City, town, or county) (State) Port Deposit, Md. Rural	
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son				ADDRESS Perryville, Md.		24a. REC'D BY REGISTRAR Aug 27-56	
				24b. REGISTRAR'S SIGNATURE L M Worthington			

CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		SEX [REDACTED]	
AGE [REDACTED]		DATE OF BIRTH [REDACTED]	
PLACE OF BIRTH [REDACTED]		DATE OF DEATH [REDACTED]	
TIME OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]	
CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]	
SIGNATURE OF PHYSICIAN [REDACTED]		SIGNATURE OF REGISTRAR [REDACTED]	
CITY [REDACTED]		COUNTY [REDACTED]	
STATE [REDACTED]		ZIP CODE [REDACTED]	

BUREAU V. 1

AUG 29 1956

RECEIVED

8239

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Hartford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 11 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen	
3. NAME OF DECEASED (Type or print) First Middle Last Joseph A. Wheeler		4. DATE OF DEATH Month August Day 19 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-22-92
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dispatcher		10b. KIND OF BUSINESS OR INDUSTRY Automotive (Gov't)	
11. BIRTHPLACE (State or foreign country) Bel Air, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Barnett Wheeler (Deceased)		14. MOTHER'S MAIDEN NAME Agnes Bradley (Deceased)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> WW-1		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 193X Bronchopneumonia, unresolved DUE TO (b) Glioblastoma, multiforme of brain, recurrent DUE TO (c) involving right occipital and parietal lobes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 3-4 Days Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. VA		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-8-1956 to 8-19-1956, and that death occurred at 2:35A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>William M. Harris M.D.</i> M.D.			
PHYSICIAN'S NAME (Type) WILLIAM M. HARRIS, M.D., Acting Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-19-56	22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens	22d. LOCATION (City, town, or county) (State) Bel Air, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE <i>John F. Sarring</i>		24a. REC'D BY REGISTRAR DATE 8-19-56	
24b. REGISTRAR'S SIGNATURE <i>James E. Dougherty</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained for use in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

FILE NO. 18

DEATH OF *JOHN J. BROWN*
 DATE OF DEATH *10-1-55*
 PLACE OF DEATH *HOME*

REPORTED BY *JOHN J. BROWN*

FILE NO. 18

DATE OF DEATH *10-1-55*

PLACE OF DEATH *HOME*

REPORTED BY *JOHN J. BROWN*

DATE OF DEATH *10-1-55*

PLACE OF DEATH *HOME*

REPORTED BY *JOHN J. BROWN*

DATE OF DEATH *10-1-55*

PLACE OF DEATH *HOME*

REPORTED BY *JOHN J. BROWN*

DATE OF DEATH *10-1-55*

PLACE OF DEATH *HOME*

REPORTED BY *JOHN J. BROWN*

DATE OF DEATH *10-1-55*

PLACE OF DEATH *HOME*

REPORTED BY *JOHN J. BROWN*

DATE OF DEATH *10-1-55*

PLACE OF DEATH *HOME*

REPORTED BY *JOHN J. BROWN*

DATE OF DEATH *10-1-55*

PLACE OF DEATH *HOME*

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DATE OF DEATH *10-1-55*

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REPORTED BY *JOHN J. BROWN*

DATE OF DEATH *10-1-55*

PLACE OF DEATH *HOME*

REPORTED BY *JOHN J. BROWN*

DATE OF DEATH *10-1-55*

PLACE OF DEATH *HOME*

REPORTED BY *JOHN J. BROWN*

DATE OF DEATH *10-1-55*

PLACE OF DEATH *HOME*

BUREAU V. S.

AUG 21 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08216

Reg. Dist. No. 92

8240

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Md. b. COUNTY Cecil				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton Rural			c. LENGTH OF STAY IN 1b lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton Rural			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Siri First Willis Middle Last				4. DATE OF DEATH Month 8 Day 9 Year 1956				
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-23-1906		
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Minnesota		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Oscar Johnson				14. MOTHER'S MAIDEN NAME Katie F. Pasorla				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Address Walter Willis, Elkton, R.D. Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 400.1 DUE TO (b) Malignant Hypertension DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p> </div> <div style="width: 15%; border: 1px solid black; padding: 5px;"> INTERVAL BETWEEN ONSET AND DEATH </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____</p>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE R. C. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) R. C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 8-10-56				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-12-1956		22c. NAME OF CEMETERY OR CREMATORY North East Cemetery		22d. LOCATION (City, town, or county) (State) North East Md.		
23. FUNERAL DIRECTOR'S SIGNATURE W. Henry Tiffin				24a. REC'D BY REGISTRAR DATE 8/14/56		24b. REGISTRAR'S SIGNATURE J. R. Frazer		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

AUG 15 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 14 Film G201 8-13-56 et

08217

8241

CERTIFICATE OF DEATH

Reg. Dist. No. 94

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Cecil		MARYLAND		STATE Maryland		COUNTY Cecil	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN North East		LENGTH OF STAY (in this place) 56 years		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN North East			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) William P Wyre				4. DATE OF DEATH (Month) (Day) (Year) August 3 1956			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Feb 25, 1880	9. AGE last birthday 76 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fish Net Maker			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Eli Wyre				14. MOTHER'S MAIDEN NAME Frances Frezze			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. none		17. INFORMANT & ADDRESS Howard Wyre North East, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.0 IMMEDIATE CAUSE (A) Arteriosclerotic Heart Disease						INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
ANTECEDENT CAUSE(S) DUE TO (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M. <input type="checkbox"/> Not while at work <input type="checkbox"/> While at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Feb 1956, to 3 Aug 1956, that I last saw the deceased alive on 27 July 1956, and that death occurred at 4 A.M. from the causes and on the date stated above.							
SIGNATURE Klaus H. Henschel				DATE SIGNED 3 Aug '56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF August 6, 1956		NAME OF CEMETERY OR CREMATORY Methodist		LOCATION (City, town, or county) (State) North East, Cecil Co, Md	
24. REC'D BY REGISTRAR DATE aug 6-1956		REGISTRAR'S SIGNATURE Sarah C. Rothemel		25. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant ADDRESS North East, Maryland			

CERTIFICATE OF DEATH

ATLANTIC STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

DEATH OF PERSON

NAME

AGE

SEX

RACE

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DEATH NUMBER

SEX

AGE

RACE

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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BUREAU V. S.

AUG 8 1956

RECEIVED

TO THE DIRECTOR OF THE BUREAU OF VITAL STATISTICS
ATLANTIC STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.